Dear treasured clients,

Welcome to 2026! We are excited to continue being an integral part of your healing journey so you can participate in your life more fully! Please note the following policies/recommendations:

*__All cancellations need to be made by calling the office__. A late cancellation is defined as an appointment not cancelled 24 hours prior to your scheduled appointment. If you have a Monday appointment that needs to be rescheduled, please call and leave a message on our office message machine 970-256-8449.
Please initial _____

*Your first late cancellation or no-show appointment in each calendar year will not be charged as we certainly understand things happen in life that make it impossible or pose a significant hardship to keep our agreed session time to focus on your health. *Please initial*_____

*After the first "free" late cancellation or no-show appointment in a calendar year, clients will be charged for the full rate of the appointment. *Please initial*_____

*After using your first “free” late cancellation or no-show appointment **and** paying for a late cancellation or no-show appointment, we will ask that you have a credit card on file for scheduling future appointments. We will notify you of the late cancellation or no-show appointment and the amount prior to charging your card.
Please initial _____

*Also, we respectfully recommend you do not smoke cigarettes or be under the influence of any recreational mind-altering substance the day of your service so that you may reap the full benefits of the service rendered.

With gratitude and appreciation,
Your Healing Horizons Healing Team

_____ **2026**
Signature Date

Healing Horizons

Integrated Health Solutions

WETTSTEIN ENDOCRINOLOGY CONSENT
@ Healing Horizons
Welcome to Healing Horizons Integrated Health Solutions

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name_____ Age_____ DOB_____ M F Marital Status_____ Phone_____

Address_____City/State_____Zip_____

Cell_____ If we may send you information, please provide your email_____

Occupation_____ Emergency Contact_____ Relation_____ Phone_____

Who referred you to Healing Horizons? _____ May we thank him/her? Y N

*I voluntarily consent to be treated by Markus Wettstein, MD.

Patient's Rights

* Wettstein Endocrinology is HIPAA (Health Insurance Portability and Accountability Act) compliant. A complete copy of HIPAA guidelines is available upon request.
* The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
* The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
* In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Dr. Wettstein's medical practice (license #DR.0047595) is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Director of Professions and Occupations, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800.

*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay,* DAOM, LAc; *Joseph Ellerin,* LAc, LMT, Dip.Hom, CST; *Kimberly Brown*, LAc, WEMT*; Paula King,* PhD; *Mariel Steel*, LMT; *April Ordaz,* LMT; *Judith Olesen*, BA; *Markus Wettstein*, MD; *Adam Henby*, DC. I also understand that other methods of collaboration, such as confidential email and private electronic group communication, may be used to coordinate my care in accordance with HIPAA regulations. ***Please initial for consent***_____

I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. Healing Horizons gladly accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. Please initial_____

I have carefully read, and I understand all of the above information. I am fully aware of what I am signing.

_____

Signature (Patient/Parent/Guardian) Date Rev 7/7/2026

Wettstein Endocrinology
Review Of Systems

Name:_____ Date: _____

Please circle all applicable symptoms.

SKIN Hair or nail changes. Rashes. Stretch marks- purple. Easy bruising.

EYES Change in vision. Double vision. Dry eyes. Reddened. Bulging.

EARS Change in hearing. Ringing. Dizziness.

NOSE Bleeds. Stuffiness.

MOUTH/THROAT Hoarseness. Sore tongue. Bleeding gums.

NECK: Lumps. Scars. Lymph nodes. Goiter. Swallowing difficulties.

BREAST: Pain. Lumps. Breast discharge.

RESPIRATORY/CARDIAC: Shortness of breath. Wheezing. Cough - productive. Fever. Night sweats.
High blood pressure. Swelling of hands/feet. Discolored fingers/toes. Heart murmur. Skipping beats.
Bronchitis/emphysema.

GASTROINTESTINAL: Change in weight. Nausea. Heartburn. Vomiting. Heartburn. Constipation.
Diarrhea. Abdominal pain. Rectal bleeding/Hemorrhoids.

URINARY: Frequent urination at night. Urgency. Incontinence.

Female: Start of cycles Year: Cycles ended: Year: Irregular. Sex drive.

Male: morning erections. Sex drive.

VASCULAR: Leg cramps. Varicose veins. Blood clots.

MUSCULOSKELETAL: Broken bones. Decrease in body height. Arthritis. Gout. Pain. Loss of toes.

HEMATOLOGIC: Anemia. Transfusions. Swollen glands.

NEUROLOGIC: Headaches. Seizures. Tremors. Numbness. Paralysis. Neuropathy.

ENDOCRINE: Abnormal growth/development. Excessive thirst. Excessive weight. Thyroid issues.
Sweating. Cold intolerance. Blood pressure spikes/ anxiety attacks. Diabetes.

PSYCHIATRIC: Anxiety. Depression. Suicidal thoughts. Memory or Sleep problems.

Healing Horizons

Integrated Health Solutions

Authorization to Disclose Personal Health Information

Patient Name: _____ Date of Birth: ____/____/____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

3. *The type of information to be used or disclosed is as follows (include dates & specifications where appropriate):*

- € Problem List
- € Medication List
- € List of Allergies
- € Immunization Records
- € Most Recent History
- € Lab Results: _____
  _____
- € X-ray and/or MRI Reports: _____
- € Other: _____
  _____
- € Physical Exams
- € Consultation Reports from (please supply doctors' names):
- € Entire Record
- € Information related to treatment for any sexually transmitted disease, including HIV or AIDs*
- € Information related to treatment for mental health-related illnesses*

*Must be checked for that specific information to be released.

4. *This information may be disclosed to and used by the following individual or organization:*

Name: _____Healing Horizons_____ Phone: __970-256-8449_____ Fax: __970-241-2828_____

Address: __2139 N. 12th Street #7_____ City: _Grand Junction_____ State: __CO___ Zip: __81501___

5. *I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.*
6. *This authorization will expire on (insert date or event):* _____
   If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.
7. *I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.*
8. *I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.*

Patient/Guardian Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____